Type of Program: ☐ Nursing Facility
☐ GAPP
☐ TEFRA/Katie Beckett

PEDIATRIC DMA 6(A)

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:	2. Medicaid Number:	3. Social Security Number
Name: _____	_____	4. Sex Age 4A. Birthdate
Address: _____		
_____	5. Primary Care Physician: _____	
DFCS County: _____	6. Applicant's Telephone # _____	

7. Does guardian think the applicant should be institutionalized? ☐ Yes ☐ No	8. Does child attend school? ☐ Yes ☐ No	9. Date of Medicaid Application _____/_____/_____

Name of Caregiver #1: _____ Name of Caregiver #2: _____

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Georgia Department of Community Health and the Department of Human Services, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

10. Signature: _____ 11. Date: _____/_____/____
(Parent or other Legal Representative)

Section B – Physician's Report and Recommendation

12. History: *(attach additional sheet if needed)*

13. Diagnosis	1. ICD	2. ICD	3. ICD
1) _____ 2) _____ 3) _____ *(Add attachment for additional diagnoses)*			

14. **Medications**				15. **Diagnostic and Treatment Procedures**	
Name	Dosage	Route	Frequency	Type	Frequency

16. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)**

Previous Hospitalizations: _____ Rehabilitative Services: _____ Other Health Services: _____

Hospital Diagnosis: 1) _____ 2) Secondary _____ 3) Other _____

17. Anticipated Dates of Hospitalization: _____	18. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

19. Type of Recommendation: ☐ Initial ☐ Change Level of Care ☐ Continued Placement	20. Patient Transferred from (check one): ☐ Hospital ☐ Another NF ☐ Private Pay ☐ Lives at home	21. Length of Time Care Needed ____ Months 1) ☐ Permanent 2) ☐ Temporary_____estimated	22. Is patient free of communicable diseases? ☐ Yes ☐ No

23. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services

24. Physician's Name (Print): _____

Physician's Address (Print): _____

25. I certify that this patient requires the level of care provided by a nursing facility, IC/MR facility, or hospital

_____ **Physician's Signature**

26. Date signed by Physician _____/_____/____

27. Physician's Licensure No. _____

28. Physician's Telephone #: _____

Section C– Evaluation of Nursing Care Needed (check appropriate box only)

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral S tatus
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/GT ☐ Meds	☐ Age Dependent Incontinence ☐ Incontinent - Age > 3 years ☐ Colostomy ☐ Continent ☐ Other _____	☐ Monitoring ☐ CPAP/Bi-PAP ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs > 2/days ☐ Therapy ☐ Oxygen ☐ Home Vent ☐ Trach ☐ Nebulizer Tx ☐ Suctioning ☐ Chest - Physical Tx ☐ Room Air	☐ Prosthesis ☐ Splints ☐ Unable to ambulate > 18 months old ☐ Wheel chair ☐ Normal	☐ Agitated ☐ Cooperative ☐ Alert ☐ Developmental Delay ☐ Mental Retardation ☐ Behavioral Problems (please describe, if checked) ☐ Suicidal ☐ Hostile
34. Integument System	**35. Urogenital**	**36. Surgery**	**37. Therapy/Visits**	**38. Neurological Status**
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☐ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age > 3 years ☐ Catheterization ☐ Continent	☐ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	Day care Services ☐ High Tech - 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 per month ☐ None	☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal

39. Other Therapy Visits	40. Remarks
☐ Five days per week ☐ Less than 5 days per week	

41. Pre-Admission Certification Number: _____ | 42.Date Signed _____/____/____

43. Print Name of MD or RN: _____

Signature of MD or RN: _____

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date: _____ Admission Date: _____ Approved for _____ Days or _____ Months

45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution?

☐ Yes ☐ No

46A. State Authority MH & MR Screening
Level I/II
Restricted Auth. Code Date
46B. This is not a re-admission for OBRA purposes
Restricted Auth. Code Date

47. Hospitalization Precertification ☐ Met ☐ Not Met

48. Level of Care Recommended by Contractor ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

49. Approval Period	50. Signature (Contractor)	51. Date	52. Attachments (Contractor)
	_____	_____/____/____	☐ Yes ☐ No